UNITED CONCORDIA
TRICARE DENTAL PROGRAM

OCONUS Provider Manual

TRICARE

You have been selected as an OCONUS (or “outside the Continental United States”) dentist to provide treatment for members enrolled in the TRICARE Dental Program (TDP). The TDP is a comprehensive dental plan available to family members of active duty Uniformed Services personnel and to Selected Reserve (SELRES) and Individual Ready Reserve (IRR) members and their family members.

This manual has been developed to familiarize you with the TDP and the policies to be used for claims submission, payment, and appeals. Further information can be found in the TDP Benefits Booklet or obtained by contacting the appropriate Overseas Lead Agent, your local Overseas Dental Treatment Facility (ODTF), or the Government contractor for the TDP, United Concordia.

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United States Government Representatives

This overseas dental program is the joint responsibility of the United States Department of Defense (for the Defense Secretariats and Agencies), the Department of Transportation (for the Coast Guard), the Department of Health and Human Services (for the Public Health Service) and the Department of Commerce (for the National Oceanic and Atmospheric Administration). These Secretariats and other Agencies administer the TDP overseas program through the TRICARE Management Activity (TMA), the Overseas Lead Agents, the ODTFs, and United Concordia.

The TMA provides day-to-day administration of the TDP contract and is responsible for the contractual procurement process and oversight of quality assurance and utilization review programs. Under this overseas program, the three Overseas Lead Agents (TRICARE Europe, TRICARE Pacific and TRICARE Latin America/Canada) manage the program within their respective geographic areas and work with the various ODTFs to identify qualified OCONUS dentists. The Overseas Lead Agents and ODTFs also manage the referral process, which is an integral piece of the overseas program.

Non-Remote OCONUS Locations

The OCONUS service area is categorized into *non-remote* and *remote* locations. A list is included in this manual identifying all non-remote countries/locations. Any country not on this list is classified as remote (see Attachment 1). Non-remote OCONUS locations are those areas in which the Uniformed Services have a fixed, full-time dental treatment facility. Under the OCONUS dental program, ODTFs will continue to provide dental care to TDP members. However, if the ODTF is unable to provide specific services, or if there is no space available, members may receive authorization to obtain dental care from host nation dentists. In this instance, the local ODTF will authorize the member to receive treatment from you.

This authorization is granted through the use of a Non-Availability and Referral Form (see Attachment 4), which is completed by the local ODTF. Active duty family members in non-remote locations must obtain a Non-Availability and Referral Form before visiting a designated OCONUS dentist for *non-orthodontic* dental procedures. All enrollees are required to obtain a Non-Availability and Referral Form in OCONUS non-remote locations for *orthodontic* care and must receive dental care from orthodontists listed on the OCONUS Provider Listing.

Remote OCONUS Locations

In remote OCONUS locations, the Uniformed Services have either part-time or no fixed, full-time dental treatment facilities. At these locations, procedures differ depending on the type of dental care received.

For *non-orthodontic* services, members may seek care from any host nation dentist and a Non-Availability and Referral Form is not required; however, members are encouraged to use OCONUS Provider Listings that may be available through their respective Overseas Lead Agents, U.S. Embassy or Consulate office, or from other local representatives of the U.S. Government.

For *orthodontic* services, all members must visit a designated orthodontist on the OCONUS Provider Listing and a Non-Availability and Referral Form is required.

Non-Availability and Referral Form

Active duty family members seeking care in *non-remote* locations must obtain a completed Non-Availability and Referral Form from their respective ODTF for all dental services, including orthodontics. Members in remote locations must obtain the referral form for orthodontic services only. These forms are not required for covered emergency care in either location.

Non-Availability and Referral Forms are valid for 120 calendar days from the date of issue. If you submit claims to United Concordia on behalf of the TDP member, be sure that a complete, valid referral form is attached to your bill. Should you have questions concerning the information contained on the Non-Availability and Referral Form, contact the Lead Agent office or ODTF representative listed on the form. A sample Non-Availability and Referral Form, with instructions for completing the form, is included in this manual (see Attachment 4).

Reminder: All enrollees are required to obtain a Non-Availability and Referral Form and use the OCONUS Provider Listing for orthodontic services in both non-remote and remote locations.

Note: *These forms are not blanket approvals for additional dental care. If you believe that additional dental care is needed, please discuss this with the referring ODTF or Overseas Lead Agent before performing additional services. If they determine that additional services are necessary, they will need to provide the member with a new Non-Availability and Referral Form for these additional services.*

United Concordia TDP OCONUS Claim Form

Should you decide to submit a claim directly to United Concordia, the TDP OCONUS claim form must be completed and submitted to United Concordia as soon as possible following the date of service, preferably within 60 days. However, if any claim is submitted to United Concordia more than 12 months after the month in which the service was provided, the claim will be denied for timeliness. A copy of the United Concordia TDP OCONUS Claim Form and instructions on how it is to be completed is included in this manual (see Attachment 3).

Claim Submission Procedures

Specific claims submission, processing, and payment procedures apply to OCONUS operations. These procedures must be followed to ensure timely processing of all claims. For United Concordia to process claims, the following information is needed:

- A completed claim form.
- A Dentist Bill or Statement of Charges. (If the specific service(s) provided are repeated on the claim form, a separate office bill is not needed.)
- A Non-Availability and Referral Form. (This form is required for orthodontic services for all enrollees. It is also required for non-orthodontic services for active duty family members in non-remote OCONUS locations.)

Whoever submits the claim to United Concordia must make sure all the appropriate information is provided. If the necessary information is not provided, claim payment will be denied. As an OCONUS dentist, you may either have the member pay you, or you may bill United Concordia for payment. Claims submission procedures vary depending on your office policy and whether you or the TDP member submits the claim for reimbursement.

Claims Submitted by the Member

If you are going to have the member pay for the dental services when the services are received, please provide him or her with a bill. In this case, the member should ensure that the claim form and Non-Availability and Referral Form (as necessary) are submitted to United Concordia. Your bill should include the following minimum information:

- Detailed description of the service(s) performed. Please include the applicable tooth number(s) in the description. If you are familiar with the American Dental Association codes for dental services (Current Dental Terminology or "CDT"), you may use them. (See list at Attachment 2.)
- Your complete name, address (to include country and postal mailing code), and telephone number (to include country and city code).
- Date(s) of service.
- Name of member who received the service(s).
- The Service member's full name and Social Security Number.
- Total charge for services performed. If multiple services are performed, please list the individual charges for each service provided.

Claims Submitted by the Dentist

If you are going to bill United Concordia directly for the services provided, you will need to submit a claim form and Non-Availability and Referral Form (depending on your location and the type of service(s) to be performed) with your bill. The necessary information includes:

Dentist Bill: The same information as mentioned in the "Claim Submitted by the Member" section above.

Claim Form: See instructions in Attachment 3. A separate claim form is required for each TDP member you treat.

We encourage you to complete the entire claim form to ensure all available information is considered for processing. Fields 1-14 can be completed by the member. Fields 15 through the end of the form contain information pertinent to the dental treatment. Your completion of this information would be appreciated and will expedite the processing of the claim. However, the following minimum data must be completed on the claim form in order for the claim to process:

- Your complete name, address (to include country and postal mailing code), and telephone number (to include country and city code).
- A detailed description of the service(s) provided, including applicable tooth numbers. If you are familiar with the American Dental Association codes for dental services (Current Dental Terminology or "CDT") you may use them. (See list at Attachment 2.)
- The date(s) of service.
- Your total charges. If multiple services are performed, please list the individual charges for each service provided (either on the claim form or the bill).
- The Service member's full name and Social Security Number.
- The member's (patient's) full name and address (APO/FPO or otherwise, including country).

Note: *The patient, parent or guardian must also sign the claim form in the appropriate blocks if assigning benefits to the dentist. If the patient is under 18 years old, the parent or guardian must sign the form.*

Non-Availability and Referral Form

A completed Non-Availability and Referral Form must be submitted with the claim. This form is required for orthodontic services for all enrollees. It is also required for non-orthodontic services for active duty family members in non-remote OCONUS locations. The TDP member will provide you with this form. The ODTF, Overseas Lead Agent, or designee, will complete this form in advance of the referral/treatment.

If you submit a claim to United Concordia, please send it to the following address:

United Concordia
TDP OCONUS Dental Unit
PO Box 69418
Harrisburg, PA 17106-9418
U.S.A.

We recommend claims be submitted as soon as possible, preferably within 60 days. However, if any claim is submitted to United Concordia more than 12 months after the month in which service was provided, the claim will be denied for timeliness.

Note: *If you submit the claim to United Concordia, the member may owe you a portion of your billed charges for certain procedures. This is called the cost share and applies to certain other restorative (crowns, onlays, etc.), prosthodontic, and orthodontic services. The member may also owe you a portion of your billed charges if he/she will, after this claim is processed, exceed either the annual benefit maximum or lifetime orthodontic benefit maximum. If the member has already exceeded the annual or lifetime benefit maximum or received care for non-covered services, the member is fully responsible for payment. The amount the member owes will be clearly detailed on the Dental Explanation of Benefits (DEOB) sent by United Concordia after your claim is processed.*

Claims Processing Procedures

United Concordia will begin processing your claim once it is received. Based on the description of services presented on your bill/claim form, our representatives will convert this description into compatible American Dental Association Current Dental Terminology (CDT) codes for processing.

If all information is present, the services are covered, and the member has not exceeded his or her annual or lifetime benefit maximum, we will pay the claim based on the member's benefits. Should certain required information not be included (such as a Non-Availability and Referral Form), the claim will be denied. If additional information is required, we will either write or call you and ask you to send the required data. If this additional information is provided within 28 calendar days of our request, we will process the claim. If the required information is not provided to us within 28 calendar days, the claim will be denied.

Claims Payment Procedures and Assignment of Benefits

As an OCONUS dentist, you may elect to receive payment for services directly from United Concordia or by collecting the amount due from the member. If you submit claims on behalf of the members, United Concordia will send payment directly to you in your local currency. Payments will be issued in local currency with the following exceptions:

- Dentists in Turkey will be paid in U.S. dollars.
- If the local currency is not available to United Concordia through our banking institution, reimbursement will be made in U.S. dollars.

If the member submits his or her own claims, payment will be sent to the member. If the member submits the claims, but would like your office to receive payment from United Concordia, then he/she has the option to "assign benefits" to you. This can easily be done by the member signing the appropriate section (signature block under field 14) of the TDP OCONUS Claim Form (see Attachment 3).

Reimbursement amounts are calculated based on the exchange rate in effect on the date the services were performed. If multiple services are reported on the same claim, the last date of service is used in determining the exchange rate.

A Dental Explanation of Benefits (DEOB) is a computer-generated statement that explains how services processed, including payment amounts and pertinent messages. The DEOB will identify all dollar-equivalent payments made and will include the exchange rate used in determining the payment. If you submit a claim for a member, or if the member assigns benefits to you, a DEOB will be sent to your office. If the member submits his or her own claim, only the member will receive a DEOB.

Predeterminations

The TDP covers many types of services from preventive and diagnostic services to orthodontics and prosthodontics. If you or your patient would like an estimate of the amount that will be paid under the TDP, you can request a predetermination. A predetermination is a nonbinding written estimate of the amount the plan will pay and the member's cost share

(or amount they owe you). United Concordia provides this service at no cost to you or your patient and strongly encourages the use of predeterminations for complex and costly services such as periodontal, prosthodontic, and orthodontic services.

Once the predetermination request is finalized, United Concordia will notify both you and the member by letter. Please note that predeterminations are valid for six months from the date of issuance and apply to specific procedures. If a different procedure is actually performed, the predetermination estimate will not apply.

If you submit a predetermination to United Concordia, please send it to the following address:

United Concordia
TDP OCONUS Dental Unit
PO Box 69418
Harrisburg, PA 17106-9418
U.S.A.

Note: *Predetermination requests should include a complete and valid Non-Availability and Referral Form, as necessary.*

Recoupments

If United Concordia determines that an improper/incorrect payment was made through some error on our part for specific services, we will request repayment of these specific amounts. We will notify you, in writing, why the recoupment is necessary, the amount due, your repayment options, and your appeal rights.

Appeals Process

The United States Government and United Concordia offer an appeals process in the event that you disagree with a benefit decision. Either the member or an OCONUS dentist can initiate the appeal. There are three levels to the appeals system and they must be followed in order. The first level is a reconsideration and is conducted by United Concordia. The remaining two levels, Formal Review and Hearing, are conducted by the United States Government, through the TMA. Each level of appeals has different requirements that must be followed.

Reconsideration

This is the first step in the appeals process. A request for reconsideration must be in writing and must be signed by you or the member or the member's appointed representative. Your letter should include the reason(s) you are requesting a reconsideration and a copy of the Dental Explanation of Benefits (DEOB). If you wish to submit radiographs (x-rays) or other photographs to support your reconsideration, please ensure they are mailed in an appropriate mailing envelope. Reconsideration requests must be postmarked within 90 calendar days of the issue date of the initial determination (DEOB). The issue date is located on the upper right corner of the DEOB. Both you and the member will be notified of the outcome of the reconsideration.

Note: *It is important to adhere to the specified time limits when filing appeals. Requests for appeals submitted after the time limits will be denied unless the person requesting the appeal shows he or she had no control over the delay.*

What Can and Cannot Be Appealed

To appeal a claim, there must be an amount in dispute. This means there must be a charge or portion of a charge that United Concordia has decided is not payable. The amount in dispute is calculated as the amount of money TDP would pay if the services involved had been determined to be payable. You may also appeal an adverse decision on a predetermination request.

The following issues cannot be appealed:

- Disputes regarding a requirement of law or regulation.
- The amount that United Concordia determines to be the allowable charge.
- Member eligibility.

Who Cannot Request an Appeal

Parties who cannot request an appeal:

- Dentists who are disqualified or excluded from being authorized dentists.
- Members who have an interest in receiving care or who have received care from a particular dentist who has been excluded, suspended, or terminated as an authorized dentist.
- Sponsors, parents, or guardians of members older than 18 years of age, not a party to the initial determination. However, they may represent the member if they are appointed (in writing) by the member.
- Third parties such as other insurance companies.

How to Request a Formal Review/Hearing from TMA

You may request a formal review from TMA if you disagree with United Concordia's reconsideration and if the amount in dispute is $50 or more. The letter notifying you of the result of our reconsideration will include a notice of your right to a formal review and instructions on how to request one.

Your request for a formal review must be received by TMA within 60 days from the date of the reconsideration determination. Your request must be in writing and include copies of the reconsideration determination and any other information not supplied with your original appeal request. Send your request for formal review to:

Appeals and Hearings Division
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, CO 80011-9043

If you disagree with the formal review decision and the amount in dispute is $300 or more, you may request a hearing by TMA. Within 60 days of the date of the formal review determination (the date on the letter from TMA notifying you of the results of the formal review), write to TMA at the above address.

Note: *Neither United Concordia, TMA, or any other federal agency will be responsible for any of your costs should you choose to appeal a claim decision, including costs associated with a request for a hearing with TMA.*

For Additional Information

If you have questions concerning OCONUS benefits, referral procedures, claims submission, or any other issues, you may contact United Concordia for assistance. When contacting United Concordia, whether by telephone or in writing, be sure to supply the following information:

- The Service member's name.
- The Service member's Social Security Number.
- The member's (patient's) name.
- The member's (patient's) date of birth.

Claims and all written inquires should be submitted to:

United Concordia
TDP OCONUS Dental Unit
PO Box 69418
Harrisburg, PA 17106-9418
U.S.A.

The TDP OCONUS Dental Unit is available by telephone 24 hours per day, five days per week. Customer Service Representatives are available to assist you in English, German, and Italian. If you are in the following locations, call the OCONUS Dental Unit toll free at 1-888-418-0466:

Australia	Greece	Portugal
Bahrain	Iceland	Saudi Arabia
Belgium	Italy	South Korea
Bolivia	Japan	Spain
Columbia	Netherlands	Switzerland
Egypt	Norway	Turkey
Germany	Panama	United Kingdom

In all other OCONUS locations, call 1-717-975-5017 for assistance. (This is a toll call.)

You may also contact United Concordia via electronic mail (e-mail) at oconus@.ucci.com.

Attachments

1) List of Non-Remote Countries and CONUS Locations
2) Dental Procedure Codes
3) TDP OCONUS Claim Form
4) Non-Availability and Referral Form

OCONUS Non-Remote Location Listing

(Current as of February 1, 2001)

Azores	Iceland	Spain
Bahrain	Italy/Sardinia	Turkey
Belgium	Japan	United Kingdom
Diego Garcia	Portugal	
Germany	South Korea	

Note: *All other countries not listed above are considered REMOTE locations.*

CONUS Location Listing

(Current as of February 1, 2001)

50 United States
District of Columbia
Puerto Rico
Guam
U.S. Virgin Islands

ATTACHMENT 2

Dental Procedure Codes

The following is a list of dental procedure codes covered by the TDP. Please include the applicable procedure code when completing the corresponding sections of the Non-Availability and Referral Form and the TDP Claim Form.

D0120	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
D0150	Comprehensive oral evaluation
D0160	Detailed and extensive oral evaluation
D0210	Intraoral - complete series
D0220	Periapical - first film
D0230	Periapical - each additional film
D0240	Occlusal film
D0250	Extraoral - first film
D0260	Extraoral - each additional film
D0270	Bitewing - single film
D0272	Bitewings - two films
D0274	Bitewings - four films
D0277	Vertical bitewings - 7-8 films
D0290	Posterior-anterior or lateral skull film
D0330	Panoramic film
D0340	Cephalometric film
D0425	Caries susceptibility tests
D0470	Diagnostic casts
D1110	Prophylaxis - adult
D1120	Prophylaxis - child
D1201	Prophylaxis and fluoride - child
D1203	Fluoride - child
D1204	Fluoride - adult
D1205	Prophylaxis and fluoride - adult
D1351	Sealant - per tooth
D1510	Space maintainer - fixed, unilateral
D1515	Space maintainer - fixed, bilateral
D1520	Space maintainer - removable, unilateral
D1525	Space maintainer - removable, bilateral
D1550	Recement space maintainer
D2110	Amalgam - one surface, primary
D2120	Amalgam - two surfaces, primary
D2130	Amalgam - three surfaces, primary
D2131	Amalgam - four or more surfaces, primary
D2140	Amalgam - one surface, permanent
D2150	Amalgam - two surfaces, permanent
D2160	Amalgam - three surfaces, permanent
D2161	Amalgam - four or more surfaces, permanent
D2330	Resin - one surface, anterior
D2331	Resin - two surfaces, anterior
D2332	Resin - three surfaces, anterior
D2335	Resin -four or more surfaces or incisal angle, anterior
D2337	Resin-based composite crown, anterior - permanent
D2542	Onlay - metallic - two surfaces
D2543	Onlay - metallic - three surfaces
D2544	Onlay - metallic - four or more surfaces
D2642	Onlay - porcelain/ceramic - two surfaces
D2643	Onlay - porcelain/ceramic - three surfaces
D2644	Onlay - porcelain/ceramic - four or more surfaces
D2662	Onlay - resin-based composite - two surfaces
D2663	Onlay - resin-based composite - three surfaces
D2664	Onlay - resin-based composite - four or more surfaces
D2740	Crown - porcelain/ceramic substrate
D2750	Crown - porcelain, high noble metal
D2751	Crown - porcelain, predominately base metal
D2752	Crown - porcelain, noble metal
D2780	Crown - 3/4 cast, high noble metal
D2781	Crown - 3/4 cast, predominately base metal
D2782	Crown - 3/4 cast, noble metal
D2783	Crown - 3/4 porcelain/ceramic
D2790	Crown - full cast, high noble metal
D2791	Crown - full cast, predominately base metal
D2792	Crown - full cast noble metal
D2910	Recement inlay
D2920	Recement crown
D2930	Prefab stainless steel crown - primary
D2931	Prefab stainless steel crown - permanent
D2932	Prefab resin crown
D2933	Prefab stainless steel crown - resin window
D2950	Core buildup including any pins
D2951	Pin retention
D2952	Cast post and core in addition to crown
D2954	Prefab post and core in addition to crown
D2962	Labial veneer (porcelain laminate) - laboratory
D2970	Temporary crown (fractured tooth)
D2980	Crown repair, by report
D3120	Pulp cap - indirect
D3220	Pulpotomy
D3221	Gross pulpal debridement, primary and permanent teeth
D3230	Pulpal therapy - anterior, primary tooth
D3240	Pulpal therapy - posterior, primary tooth
D3310	Root canal treatment - anterior
D3320	Root canal treatment - bicuspid
D3330	Root canal treatment - molar
D3332	Incomplete endodontic therapy; inoperable or fractured tooth
D3333	Internal root repair of perforation defects
D3346	Root canal retreatment - anterior
D3347	Root canal retreatment - bicuspid
D3348	Root canal retreatment - molar
D3351	Apexification - initial visit
D3352	Apexification - interim medication replacement
D3353	Apexification - final visit
D3410	Apicoectomy - anterior
D3421	Apicoectomy - bicuspid (first root)
D3425	Apicoectomy - molar (first root)
D3426	Apicoectomy - each additional root
D3430	Retrograde - per root
D3450	Root amputation - per root
D3920	Hemisection
D4210	Gingivectomy - quadrant
D4211	Gingivectomy -per tooth
D4220	Gingival curretage - quadrant
D4240	Gingival flap - quadrant
D4249	Crown lengthening - hard tissue
D4260	Osseous surgery - quadrant
D4263	Bone replacement graft - first site
D4264	Bone replacement graft - each additional site
D4266	Guided tissue regeneration - resorbable
D4267	Guided tissue regeneration - nonresorbable

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Dental Procedure Codes

D4270	Pedicle soft tissue graft
D4271	Free soft tissue graft
D4273	Subepithelial connective tissue graft
D4341	Scaling and root planing - quadrant
D4910	Periodontal maintenance
D4920	Unscheduled dressing change
D5110	Complete upper denture
D5120	Complete lower denture
D5130	Immediate upper denture
D5140	Immediate lower denture
D5211	Upper partial - resin base
D5212	Lower partial - resin base
D5213	Upper partial - cast metal with resin base
D5214	Lower partial - cast metal with resin base
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial, upper
D5422	Adjust partial, lower
D5510	Repair broken complete denture base
D5520	Replace missing/broken teeth - complete denture
D5610	Repair resin denture base
D5620	Repair cast framework
D5630	Repair or replace broken clasp
D5640	Replace broken tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5710	Rebase - complete upper denture
D5711	Rebase - complete lower denture
D5720	Rebase - upper partial denture
D5721	Rebase - lower partial denture
D5730	Reline - complete upper denture (chairside)
D5731	Reline - complete lower denture (chairside)
D5740	Reline - upper partial denture (chairside)
D5741	Reline - lower partial denture (chairside)
D5750	Reline - complete upper denture (lab)
D5751	Reline - complete lower denture (lab)
D5760	Reline - upper partial denture (lab)
D5761	Reline - lower partial denture (lab)
D5810	Interim complete denture - upper
D5811	Interim complete denture - lower
D5820	Interim partial denture - upper
D5821	Interim partial denture - lower
D5850	Tissue conditioning - upper denture
D5851	Tissue conditioning - lower denture
D6210	Pontic - cast, high noble metal
D6211	Pontic - predominately base metal
D6212	Pontic - cast, noble metal
D6240	Pontic - porcelain, high noble metal
D6241	Pontic - predominately base metal
D6242	Pontic - porcelain, noble metal
D6245	Pontic - porcelain/ceramic
D6543	Onlay - metallic - three surfaces
D6544	Onlay - metallic - four or more surfaces
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6740	Crown - porcelain/ceramic
D6750	Crown - porcelain, high noble metal
D6751	Crown - porcelain, predominately base metal
D6752	Crown - porcelain, noble metal
D6780	Crown - 3/4 cast high noble metal
D6781	Crown - 3/4 cast, predominately base metal
D6782	Crown - 3/4 cast, noble metal
D6783	Crown - 3/4 porcelain/ceramic
D6790	Crown - full cast, high noble metal
D6791	Crown - full cast, predominately base metal
D6792	Crown - full cast, noble metal
D6930	Recement bridge
D6970	Cast post and core in addition to bridge
D6972	Prefab post and core in addition to bridge
D6973	Core buildup for bridge including any pins
D6980	Bridge repair, by report
D7110	Extraction - single
D7120	Extraction - additional tooth
D7130	Root removal
D7210	Surgical extraction - erupted tooth
D7220	Soft tissue impaction
D7230	Partial bony impaction
D7240	Complete bony impaction
D7250	Surgical removal residual roots
D7260	Oroantral fistula closure
D7270	Reimplant/stabilize evulsed tooth
D7280	Surgical exposure, for orthodontics
D7281	Surgical exposure, aid eruption
D7285	Biopsy of oral tissue, hard
D7286	Biopsy of oral tissue, soft
D7290	Surgical repositioning of teeth
D7291	Fiberotomy
D7310	Alveoloplasty with extraction, quadrant
D7320	Alveoloplasty without extraction, quadrant
D7471	Removal of exostosis - per site
D7510	Incision and drainage of abscess - soft tissue
D7910	Suture small wounds to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7971	Excision - pericoronal gingiva
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8670	Periodic orthodontic treatment visit (as part of contract)
D8680	Orthodontic retention
D8690	Orthodontic treatment (alternate billing to a contract fee)
D9110	Palliative treatment
D9220	General anesthesia - first 30 minutes
D9221	General anesthesia - Each additional 15 minutes
D9241	Intravenous sedation/analgesia - first 30 minutes
D9242	Intravenous sedation/analgesia - each additional 15 minutes
D9310	Consultation, other than treating dentist
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic drug injection, by report
D9930	Treatment of complications (post surgical), by report
D9940	Occlusal guard, by report
D9941	Fabrication of athletic mouth guard
D9974	Internal bleaching - per tooth, by report

ATTENDING DENTIST'S STATEMENT

UNITED CONCORDIA

TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418 USA

Check One: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

PATIENT SECTION

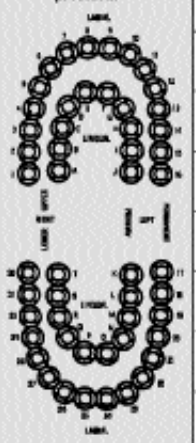
1. Patient name
2. Relationship to sponsor: self | spouse | child | other
3. Sex: m | f
4. Patient birthdate: mo | day | year
5. If full time student: school | city
6. Sponsor's name: First | middle | last
7. Sponsor's social security no.
8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)
9. Telephone number **(include country, city, and/or area code)**
10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
Signature (patient or parent if minor) | Date
11. Branch of service
12. Group name
TRICARE Dental Program
13. Is patient covered by another dental plan? ☐ yes ☐ no
Dental plan name
Insured name and soc. sec. no.
Group no.
Name and address of carrier
14. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.
Signature (insured person) | Date

DENTIST SECTION

15. Dentist name
16. Office address | City, country, postal mailing code
16a. Billing address | City, country, postal mailing code
17. Dentist phone no. (including country, city, and/or area code)
18. UCCI dentist no.
19. Dentist fax no.
20. Dentist email address
21. Point of contact name (POC), telephone no., fax no., and email address

	No	Yes	
22. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
23. Is treatment result of auto accident?			
24. Other accident?			
25. If prosthesis, is this initial placement?			(If no, reason for replacement) 26. Date of prior placement
27. Is treatment for orthodontics?			Appliance insertion date / Total length of treatment **(Non-Availability and Referral Form Necessary) ***
28. Transfer patient?			If yes, rebend date / If no, starting date of treatment
Was patient rebanded?			

Indicate tooth/ teeth no.(s) for which services were provided.



30. Remarks for unusual services

29. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.

TOOTH NO. OR LETTER U.S.	TOOTH NO. OR LETTER INTL.	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MONTH	DAY	YEAR	PROCEDURE CODE	FEE CHARGED

31. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and / or federal law and may also be subject to civil penalties. I hereby certify that the procedures as indicated by date have been completed.
Signature (Dentist) | Date

32. TOTAL FEE CHARGED

33. INDICATE CURRENCY ☐ USD ☐ LOCAL

AMOUNT PAID

5678 B 7/00 **OCONUS**

Completing the TDP OCONUS Claim Form

Most of the TDP Claim Form is self-explanatory; however, there are certain fields to which special attention should be paid:

- **Upper left corner** ("Attending Dentist's Statement"): Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.
- **Box 2. Relationship to Sponsor.** For example, self, spouse, or child.
- **Box 7. Sponsor's Social Security Number (SSN).** The sponsor's nine-digit SSN must appear on every claim form.
- **Box 8. Patient's Mailing Address.** Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, country, and postal mailing code.
- **Box 10. Release of information**.
- **Box 13. Is the patient covered by another dental insurance plan.** Check 'No' if the family member has no other dental insurance. If the family member has additional dental insurance, please check 'Yes' and include the plan name, insured name and social security number, group number, and address of the other carrier.
- **Box 14. Assignment of Benefits**. Sign if the family member, parent, or guardian wants to assign payment of benefits to the dentist; if signed, United Concordia will send payment to the dentist directly.
- **Box 15. Dentist Name.**
- **Box 16. Dentist office address.** Include street, city, country, and postal mailing code where services were performed.
- **Box 16A. Billing address.** Include street, city, country, and postal mailing code.
- **Box 17. Dentist's phone number.** Include the country code and city code, along with local number.
- **Box 27. Treatment for Orthodontics.** For orthodontic care, submit a completed copy of this claim form along with a valid Non-Availability and Referral form and the provider's bill to the address on the front of this form.
- **Box 29. Examination and Treatment Plan.** Provide a detailed description of the services performed including applicable tooth numbers, date of service, and the fee charged.
- **Box 33. Currency.** Indicate type of currency billed to patient (US dollars or local currency).

General Instructions

- Submit a separate claim form for each family member who receives treatment.

- **All claim forms should be submitted to United Concordia as soon as possible after the service date**, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.

- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years old, the parent or guardian must sign the form.

- The provider must sign the appropriate sections of the claim form.

- For orthodontic services, submit the following:
    1. A completed claim form.
    2. The dentist's bill (if the claim form is not used solely as the bill).
    3. A Non-Availability and Referral Form.

- For non-orthodontic services, submit the following:
    1. A completed claim form.
    2. The dentist's bill (if the claim form is not used solely as the bill).
    3. A Non-Availability and Referral Form for Active Duty Family Members in non-remote locations.

If all necessary information is not included, your claim may be denied.

UNITED CONCORDIA

TRICARE Dental Program

NOTE: For orthodontic services, the Sponsor/Family Member must forward this completed form and the dentist's bill for the claim to be processed. For non-orthodontic services, this form is necessary for Active Duty Family Members in non-remote locations. This form is not required for covered emergency dental care. Additional information can be found in the TDP Benefit Booklet.

NON-AVAILABILITY AND REFERRAL FORM

PATIENT INFORMATION

1) PATIENT'S NAME — LAST / FIRST / MI

2) DATE OF BIRTH — MO / DAY / YEAR

3) SEX — M / F

4) RELATIONSHIP — SPOUSE / CHILD / OTHER

5) SPONSOR'S NAME — LAST / FIRST / MI

6) SPONSOR'S SOCIAL SECURITY NUMBER

7) PATIENT'S ADDRESS (APO/FPO or Street, City, Country, Postal Mailing Code)

REFERRAL INFORMATION

8) REFERRING OVERSEAS DENTAL TREATMENT FACILITY/OVERSEAS LEAD AGENT (Name, Location, Mailing Address, Unit, and Country)

9) PRIMARY REASON FOR REFERRAL:

- ☐ a) Proper facilities or professional capability are temporarily not available at this facility.
- ☐ b) Proper facilities or professional capability are permanently not available at this facility.
- ☐ c) Orthodontic treatment.

10) REFERRED SERVICE (Description of Service - include CDT - 3 code(s) if possible)

- __ Exam
- __ Routine Prophylaxis
- __ Radiographs
- __ Fluoride Treatment
- __ Consultation
- __ Other _____
- __ Restorative
- __ Other Restorative (crown, onlay, etc.)
- __ Endodontics
- __ Orthodontics
  - __ Extensive
  - __ Diagnostic
  - __ Retainer
  - __ Appliance for Movement

11) REMARKS

12) NAME AND TITLE (Type or Print)

13) APPROVAL SIGNATURE

14) DATE OF ISSUANCE *

*** NOTE: FORM VALID FOR 120 DAYS FROM DATE OF ISSUANCE**

SPONSOR/FAMILY MEMBER CERTIFICATION

15) SPONSOR/FAMILY MEMBER CERTIFICATION

- ☐ I have confirmed my enrollment in the TDP. If I am not enrolled, I am responsible for the full cost of any dental care received.
- ☐ I confirm that, as of the date of this referral, I have not exceeded the appropriate annual/lifetime maximum. I understand that, if I have exceeded my maximums ($1200 for non-orthodontic services and $1500 for orthodontic services), I am responsible for the full cost of any additional services received.
- ☐ I understand that, if I receive services for dental care not covered under this referral, I am responsible for the full cost of any dental care received outside the scope of this referral.

SIGNATURE (Sponsor/Family Member) _____ DATE

16) I have received confirmation from the sponsor/family member that the above is true and that the sponsor/family member agrees to these certifications as of the date of this referral.

INITIALS (Referring Party) DATE

17) ODTF/OVERSEAS LEAD AGENT TRACKING NUMBER

5671 B 7/00

The information contained on this form is protected by the Privacy Act of 1974.

The quality of foreign dental care is not controlled by the Government or United Concordia or any of its agents or representatives. The fact that a foreign dentist has been determined to provide acceptable dental care in the past does not guarantee acceptable future service. The Governments control over foreign dentists is limited to their inclusion or exclusion from the OCONUS Provider List. Sponsors/Family Members should forward any complaints or concerns about foreign dental service/quality of care to their respective Overseas Lead Agent.

Completion Instructions

Patient Information and Referral Information Fields must be completed by the servicing Overseas Dental Treatment Facility/Overseas Lead Agent. Sponsor/Family Member Certification Fields must be completed by sponsor/family member. In the case of a member under the age of 18, the parent or guardian must sign on his/her behalf. If the form is being faxed/mailed to a sponsor/family member, the Government representative completing the form must first explain the certifications to the sponsor/family member and initial/date this form where appropriate.

1) Patient's Name: Enter the last name, first name, and middle initial of the person being treated.

2) Date of Birth: Enter the number of the month, day, and year of the family member's birth.

3) Sex: Check the appropriate box.

4) Relationship: Check the appropriate box.

5) Sponsor's Name: Enter the last name, first name, and middle initial of the sponsor, as it appears on the ID card.

6) Sponsor's Social Security Number: Enter the sponsor's nine-digit Social Security Number.

7) Patient's Address: Enter the home mailing address of the family member seeking dental treatment. Be sure to provide the complete address (APO/FPO or street, city, country, postal mailing code) including country.

8) Referring Overseas Dental Treatment Facility/Overseas Lead Agent: Enter the name of the Overseas Dental Treatment Facility/Overseas Lead Agent, and complete mailing address, unit, and country.

9) Primary Reason for Referral: Check the appropriate box.

10) Referred Service: Provide a detailed description of the service for which the patient is being referred. Ensure referrals are made for specific care and include the applicable CDT-3 code(s), tooth number(s) and procedure name

For Position ONLY! 80 % of original size

13) Approval Signature: Enter the signature of the person issuing the referral form.

14) Date of Issuance: Enter the date the referral form is provided to the member.

15) Sponsor/Family Member Certification: This area must be completed, signed, and dated by the sponsor/family member.

16) Referring Party Confirmation: If this form is being faxed/mailed to a sponsor/family member, the Government representative completing the form must initial and date the form **after** explaining the certification in **Field 15** to the sponsor/family member.

17) ODTF/Overseas Lead Agent Tracking Number: For use by the Overseas Dental Treatment Facility/Overseas Lead Agent.

Submit this referral form and the completed claim form to the following address:

United Concordia
TDP OCONUS Dental Unit
PO Box 69418
Harrisburg, PA 17106-9418
USA

Notes

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